U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 20 May 2004

CASE NO.: 2003-BLA-193

In the Matter of:

TERRY K. BELCHER
Claimant

v.

EASTERN ASSOCIATED COAL CORP.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

APPEARANCES:

Eugene D. Pecora, Esq.

Paul E. Frampton, Esq.
For the Employer

Before: DANIEL L. LELAND
Administrative Law Judge

DECISION AND ORDER - DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. In accordance with the Act and the pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A formal hearing was held in Beckley, West Virginia on December 3, 2003, at which all parties were afforded full opportunity to present evidence and argument, as provided in the Act and the regulations found in Title 20 Code of Federal Regulations. Regulation section numbers mentioned in the Decision and Order refer to sections of that Title. At the hearing, Director's exhibits (DX) 1-117 and Employer's exhibit (EX) 1 were admitted into evidence. Also at the hearing, Employer was allowed sixty days to have a series of chest x-rays and the CT scan read by one doctor and to depose Drs. Zaldivar and Tuteur. Claimant was allowed sixty days to respond to any evidence submitted by Employer. In an Order issued February 4, 2004, I admitted Drs. Wheeler, Scott, and Scatarige's re-readings of chest x-rays dated April 29, 1991, October 6, 1992, December 15, 1994, June 19, 1996, and November 17, 1997 as EX 2 and Drs. Wheeler, Scott, and Scatarige's re-readings of the November 5, 2003 chest x-ray as EX 3. I now admit Dr. Zaldivar's deposition dated January 27, 2004 as EX 4 and Dr. Tuteur's deposition dated February 23, 2004 as EX 7. Also, I now admit Dr. Scatarige's interpretation of the November 5, 2003 CT scan as EX 6.[1] In response to Employer's evidence, Claimant submitted a letter from Dr. Maria Boustani dated January 27, 2004, which is now admitted as Claimant's exhibit (CX) 1. Claimant and Employer submitted timely briefs.

ISSUES

I. Existence of pneumoconiosis.

II. Causal relationship of pneumoconiosis and coal mine employment.

III. Existence of total disability.

IV. Causation of total disability.

FINDINGS OF FACT AND CONCLUSIONS OF LAW[2]

Procedural History

This case has a lengthy procedural history. Terry K. Belcher (Claimant or miner) filed the instant claim for benefits on March 6, 1991. (DX 1). On July 3, 1991, the district director made an initial finding that Claimant was entitled to benefits, which Employer appealed on August 14, 1991. (DX 19-20). Administrative Law Judge Victor Chao held a hearing on

[1] Employer submitted interpretations of a series of chest x-rays and CT scans by Dr. Scott as EX 5. As discussed above, I admitted a series of x-ray interpretations by Drs. Wheeler, Scott, and Scatarige in an Order issued February 4, 2004. In that Order, I stated that "I find that this chest x-ray evidence [EX 2 and 3] satisfies Employer's request at the hearing for additional time to submit interpretations of several chest x-rays between 1991 and 2003." I find that the additional interpretations of chest x-rays and CT scans at EX 5 exceed my ruling at the hearing, and thus they are excluded from the record.

[2] The following abbreviations have been used in this decision and order: TR = transcript of hearing, BCR = board-certified radiologist, B = B-reader.

October 20, 1992. (DX 29). On December 8, 1992, Judge Chao issued an Order of Remand for the development of CT scan evidence. (DX 31). On May 27, 1993, the district director issued a Proposed Decision and Order awarding benefits to Claimant. (DX 36). Employer appealed the district director's finding on June 3, 1993. (DX 37). On October 7, 1993, Administrative Law Judge John C. Holmes held a hearing, at which Claimant did not testify. (DX 40). Judge Holmes issued a Decision and Order – Granting Benefits on November 29, 1994. (DX 43). Employer appealed to the Benefits Review Board ("Board") on December 9, 1994, and the Board issued a decision and order on April 30, 1996, affirming in part and reversing in part. (DX 61). Specifically, the Board affirmed Judge Holmes' findings of length of coal mine employment and coal workers' pneumoconiosis, but vacated his findings of total disability and the discrediting of Drs. Zaldivar and Tuteur. On September 23, 1996, Judge Holmes issued a Decision and Order – On Remand, again finding that Claimant was entitled to benefits. (DX 66). In that decision, Judge Holmes urged one of the parties to seek a remand or modification "to obtain the medical evidence not previously submitted and the new 'objective' medical evidence so that a clearer determination can be made as to whether or not Claimant's apparent pulmonary disability is compensable under the Act." (DX 66, p. 4). Employer filed a Motion for Reconsideration on October 17, 1996. (DX 68). Judge Holmes granted Employer's Motion on October 31, 1996, and remanded the case to the district director for the development of additional medical evidence pursuant to § 725.456(e). (DX 71). After Claimant and Employer submitted additional medical evidence, the district director issued a Proposed Decision and Order on June 11, 1998, modifying Judge Holmes' decision and order issued November 29, 1994 to a denial because of a mistake in a determination of fact pursuant to § 725.310. (DX 92). Claimant appealed on June 18, 1998. (DX 94). On February 5, 1999, Administrative Law Judge Pamela Lakes Wood issued an Order of Remand for the further development of evidence. (DX 101). In particular, Judge Wood instructed the district director to have the December 1997 and November 1998 CT scans interpreted by an independent reviewer, to obtain the original interpretation of the December 1997 CT scan, and to have Claimant tested for tuberculosis. (DX 101). The district director had Dr. Navani interpret the CT scans and the case was then referred to the Office of Administrative Law Judges on May 9, 2003. (DX 113, 115, 117).

Background

Claimant was born on November 1, 1946 and has one dependent, his wife, Nadine. (TR 20; DX 1). Claimant and Employer stipulated to seventeen years of coal mine employment. (TR 6-7). Claimant's last jobs were as a roof bolter and a miner operator; he performed each job for six months. (TR 15). He explained that both of these positions involved operating machinery in a sitting position with levers. (TR 16-17). When Claimant worked as a roof bolter, he would spend three-quarters of a shift roof bolting and one-fourth of a shift putting up headers and rock dusting. (TR 17). Claimant testified that he wore a respirator. (TR 10). Claimant worked in the coal mine until 1987. (TR 10, 14).

Claimant testified that he began smoking at age eighteen and quit smoking in 1998. (TR 20). Claimant smoked one-half a pack of cigarettes per day. (TR 11). Claimant can no longer do chores around the house, but he sometimes works with wood. (TR 13). Claimant has shortness of breath and a productive cough at night. (TR12, 14). He takes medication for his breathing and has been on oxygen at night for about eight months. (TR 21-22).

Claimant's wife testified that Claimant began having breathing problems in the late 1980s. (TR 24). She also testified that Claimant takes four or five medications for his breathing problems. (TR 26).

Medical Evidence

The summary of medical evidence in Judge Holmes' November 29, 1994 and September 23, 1996 decisions and orders are incorporated by reference. The following summary is of evidence submitted since the issuance of the September 23, 1996 decision and order.

Chest x-rays

Exhibit	**Date**	**Physician**	**Interpretation**
EX 2	4/29/91	Scatarige, BCR, B	no pneumoconiosis; "2.5×3.5 cm spiculated mass R apex – TB, fibrosis, cancer?;" bullous emphysema
EX 2	4/29/91	Scott, BCR, B	no pneumoconiosis; "4×2 cm probable focal fibrosis right apex;" bullous emphysema left upper lung
EX 2	4/29/91	Wheeler, BCR, B	no pneumoconiosis; "3×2 cm mass subapical RUL with 7 cm linear scar… compatible with inflammatory disease or tumor;" moderate emphysema with bullous bleb left upper lung and apex
EX 2	10/6/92	Scatarige, BCR, B	no pneumoconiosis; "2.5×3.5 cm spiculated mass R apex – ? cancer, TB, focal fibrosis?;" bullous emphysema LUL>RUL
EX 2	10/6/92	Scott, BCR, B	no pneumoconiosis; "2×4 cm probable focal fibrosis right apex;" bullous emphysema upper lungs, L>R
EX 2	10/6/92	Wheeler, BCR, B	no pneumoconiosis; "2.5 cm mass subapical RUL with 6 cm linear scar… compatible with inflammatory disease such as TB or possible tumor;" moderate emphysema with bullous bleb left upper lung and apex
EX 2	9/20/93	Scatarige, BCR, B	no pneumoconiosis; "2.5×3.5 cm opacity right apex – probably calcified – and probably healed TB;" bullous emphysema

Exhibit	Date	Physician	Interpretation
EX 2	9/20/93	Scott, BCR, B	no pneumoconiosis; "2×4 cm probable focal fibrosis right apex;" bullous emphysema upper lungs, L>R
EX 2	9/20/93	Wheeler, BCR, B	no pneumoconiosis; "2.5 cm mass subapical RUL with 6 cm linear scar… compatible with inflammatory disease such as TB or treated tumor;" moderate emphysema with bullous bleb left upper lung and apex
EX 2	9/22/94	Scatarige, BCR, B	no pneumoconiosis; "calcified 2.5×4.0 cm spiculated RUL mass – probably healed TB;" bullous emphysema, LUL>RUL
EX 2	9/22/94	Scott, BCR, B	no pneumoconiosis; "2×4 cm scar right apex;" bullous emphysema upper lungs, L>R
EX 2	9/22/94	Wheeler, BCR, B	no pneumoconiosis; "2.5 cm mass subapical RUL with 6 cm linear scar… compatible with inflammatory disease such as TB or treated tumor;" moderate emphysema with bullous bleb left upper lung and apex
DX 75	12/15/94	Patel, BCR	underlying mild COPD, associated with large left upper zone bulla and left basal mild bullous changes; mild to moderate profusion of small opacities throughout the lungs, associated with stable, right apical, irregular, nodular large opacity or nodular scar, classifiable as complicated pneumoconiosis
EX 2	12/15/94	Scatarige, BCR, B	no pneumoconiosis; "2.5×3.5 cm calcified mass in RUL – probably healed TB;" bullous emphysema
EX 2	12/15/94	Scott, BCR, B	no pneumoconiosis; "2×4 cm scar with calcification right apex, probably healed TB;" bullous emphysema upper lungs, L>R

Exhibit	Date	Physician	Interpretation
EX 2	12/15/94	Wheeler, BCR, B	no pneumoconiosis; "2.5 cm mass subapical RUL with 6 cm linear scar… compatible with inflammatory disease such as TB or treated tumor;" moderate emphysema with bullous bleb left upper lung and apex
DX 75	6/19/96	Gangloff	very small peripheral bilateral nodules compatible with simple pneumoconiosis with and complicated pneumoconiosis of the right apex; large bulla at the left apex
DX 75	6/19/96	Patel, BCR	mild hyperinflation with very small peripheral bilateral nodules compatible with simple pneumoconiosis and with complicated pneumoconiosis of the right apex; large bulla at the left apex
EX 2	6/19/96	Scatarige, BCR, B	no pneumoconiosis; "calcified, spiculated mass in R apex – c/w healed TB;" bullous emphysema, LUL>RUL
EX 2	6/19/96	Scott, BCR, B	no pneumoconiosis; "2×4 cm scar with calcification right apex, probably healed TB;" bullous emphysema upper lungs, L>R
EX 2	6/19/96	Wheeler, BCR, B	no pneumoconiosis; "2.5 cm mass subapical RUL with 6 cm linear scar… compatible with inflammatory disease such as TB or treated tumor;" moderate emphysema with bullous bleb left upper lung and apex
DX 91	8/27/97	Sargent, BCR, B	1/0, s/t, but not consistent with pneumoconiosis because there are no small rounded opacities and the predominance of the disease is at the bases of the lungs; bullous emphysema; calcified infiltrate in right upper lobe is not a large opacity of pneumoconiosis and is apparently due to old granulomatous disease
DX 86	8/27/97	Zaldivar, B	no pneumoconiosis; "what appears to be pneumoconiosis is granulomatous scar and bullous emphysema"

Exhibit	Date	Physician	Interpretation
EX 2	9/17/97	Scatarige, BCR, B	no pneumoconiosis; "calcified, spiculated lesion RUL, stable, healed TB;" bullous emphysema
EX 2	9/17/97	Scott, BCR, B	no pneumoconiosis; "2×4 cm scar with calcification right apex, probably due to healed TB;" bullous emphysema upper lungs, L>R
EX 2	9/17/97	Wheeler, BCR, B	no pneumoconiosis; "2.5 cm mass subapical RUL with 6 cm linear scar… compatible with inflammatory disease such as TB or treated tumor;" moderate emphysema with bullous bleb left upper lung and apex
DX 100, 102	2/1/98	Lintala	linear scarring at right lung apex and left lung base; diffuse pulmonary emphysema
DX 100	2/6/98	Thompson	no change in the chronic obstructive pulmonary disease and the old fibrolinear scar changes in the right upper lobe
DX 100	2/10/98	Lintala	pleural thickening and scarring at right lung apex; faint reticular nodular pattern of pulmonary interstitium of both lungs; linear fibrotic changes in both lung bases
DX 100	2/13/98	Lintala	faint, reticular, nodular pattern of the pulmonary interstitium of both lungs, consistent with coal workers' pneumoconiosis; linear scarring in right lung apex and left lung base and large bulla in left lung apex, consistent with diffuse pulmonary emphysema
DX 100, 102	6/17/98	Dehgan	few small linear and nodular densities of lower lung field; scarring of right upper lung and emphysematous change of left upper lung with probability of large bullous in left upper lung area
EX 3	11/5/03	Scatarige, BCR, B	no pneumoconiosis; bullous emphysema in both apices
EX 3	11/5/03	Scott, BCR, B	no pneumoconiosis; "calcified granulomata, bullae, linear scars apices"

Exhibit	Date	Physician	Interpretation
EX 3	11/5/03	Wheeler, BCR, B	no pneumoconiosis; "2 cm mass subapical RUL with few adjacent linear scars compatible with inflammatory disease but I cannot r/o tumor with minimal lymphatic spread; hyperinflation lungs compatible with deep breath or emphysema with decreased upper lung markings favoring emphysema; 5 mm nodule subapical LUL compatible with granuloma"
EX 1	11/5/03	Zaldivar, B	no pneumoconiosis

CT scans

Dr. George L. Zaldivar interpreted the December 8, 1997 CT scan in his report dated February 13, 1998. (DX 86). Dr. Zaldivar found that the CT scan was more compatible with an inflammatory disease of the lungs rather than coal workers' pneumoconiosis. Dr. Zaldivar stated that there was no evidence of pneumoconiosis in the CT scan. He explained that "what give[s] the appearance of simple pneumoconiosis in the chest radiographs is nothing more than emphysematous bullae which are superimposed on each other." (DX 86, p. 4). Dr. Zaldivar concluded that the CT scan revealed emphysematous bullae with inflammatory disease that has resulted in granulomas.

Dr. E. Nicholas Sargent interpreted the December 8, 1997 CT scan in a report dated April 22, 1998. (DX 91). Dr. Sargent found bilateral diffuse extensive emphysema, with numerous bullae, that are compressing the surrounding lung tissues and contributing to the findings of small irregular opacities on the chest x-rays. He stated that there were no small rounded opacities and that the right upper lobe infiltrate, which is surrounded by numerous bullae, does not have the appearance of a large opacity, and thus it is not due to coal workers' pneumoconiosis. Dr. Sargent concluded that the findings are more likely associated with advanced emphysematous changes consistent with the miner's history of heavy smoking rather than coal workers' pneumoconiosis.

Dr. Shiv Navani, a board-certified radiologist, interpreted the December 8, 1997 CT scan in a report dated November 10, 2002. (DX 115-116). Dr. Navani found a large bullous area occupying the entire left upper chest cavity filled with an inordinate amount of trapped air. He stated that this area amounted to one-fourth of both lung fields and is functionless, causing compression of the rest of the left lower lung fields, giving the false impression of greater perfusion of small densities in the left lower lung fields. Dr. Navani also found smaller bullous areas in the right upper lung zone and innumerable round areas of diminished attenuation in both lung fields, which are indicative of severe pulmonary centri-acinar emphysema. Dr. Navani found small linear and round densities affecting the right lung and the left mid and lower zones, consistent with 1/2, t/q changes of pneumoconiosis. However, he stated that these changes are non-specific and could be due to a variety of other conditions, such as sarciodosis, scleroderma, drug-induced pulmonary fibrosis, or fibrosing alveolitis. Dr. Navani stated that the fibro-calcific

densities in the right upper zone do not appear to be changes related to coal workers' pneumoconiosis, but rather appear to be due to an inflammatory disease in the remote past, such as histoplasmosis or tuberculosis. Finally, he found no evidence of complicated pneumoconiosis.

Dr. Manu N. Patel interpreted the November 20, 1998 CT scan. (DX 100, 108).[3] He found a mild profusion of small opacities throughout all lung zones associated with a stable, centrally calcified, irregular, spiculated, retractive nodular mass infiltrate in the right upper lung compatible with a Category A large opacity of complicated pneumoconiosis or a retractive fibrosis associated with old, healed tuberculosis. Dr. Patel found severe, large, thin-walled bullous changes in the left upper lung zone and smaller, thin-walled bullous changes in the right upper lung zone. He also found minimal, generalized, centrilobular emphysema predominantly in the upper and mid lung zones. Finally, Dr. Patel identified occasional, calcified granulomas in the right upper lung zone.

Dr. Zaldivar interpreted the November 5, 2003 CT scan. (EX 1). Dr. Zaldivar found evidence of bullous emphysema throughout the upper and mid portions of both lungs. He also found an irregular partially calcified mass in the left upper lobe, which was the result of an old infection. He noted that there were small calcified nodules around this mass, which were also due to the infection. Dr. Zaldivar found no evidence of pneumoconiosis.

Dr. John C. Scatarige interpreted the November 5, 2003 CT scan. (EX 6). Dr. Scatarige found centrilobular emphysema in the upper and middle thirds of each lung. He also found large bullae in the upper lobes. Dr. Scatarige identified a 2×3 cm mass in the right upper lobe with coarse calcifications that he opined was a calcified granuloma. He found no evidence of coal workers' pneumoconiosis or silicosis.

Pulmonary Function Studies

Exhibit	**Date**	**Height**	**Age**	**FEV1**	**FVC**	**MVV**
DX 86	8/27/97	71"	50	1.75 1.83*	3.70 3.88*	77 79*
DX 100	4/23/98	70"	51	1.83 2.03*	3.46 4.07*	73 74*
EX 1	11/5/03	71"	57	1.95 2.20*	4.01[4] 4.50*[5]	--- ---*

[3] Dr. Patel reviewed the October 11, 1993 CT scan and June 19, 1996 and November 17, 1997 chest x-rays in the course of interpreting the November 20, 1998 CT scan.

[4] The FEV1/FVC ratio is 48.6%.

[5] The FEV1/FVC ratio is 48.8%.

* post-bronchodilator

Blood Gas Studies

Exhibit	Date	PCO2	PO2
DX 75	10/18/93	34.8	76
DX 86	8/27/97	35 31*	77 96*
DX 100	2/2/98	29.7	47.9
DX 100	2/13/98	32.6	57.4
EX 1	11/5/03	28 36*	66 56*

* exercise values

Medical Reports

Dr. Rasmussen reviewed Dr. Zaldivar's May 20, 1992 report and Dr. Tuteur's September 14, 1993 report and drafted a letter dated January 30, 1997. (DX 77). Dr. Rasmussen stated that "I do not believe Dr. Zaldivar's [report] implies causation other than coal mine dust exposure as a causative factor in [Claimant's] disabling lung disease" because Dr. Zaldivar found evidence of silicosis and coal miners are subject to developing silicosis. (DX 77, p. 4)(emphasis in original). Dr. Rasmussen also stated that Dr. Tuteur's opinion that coal dust exposure did not cause Claimant's pneumoconiosis is "groundless" because the silica content of coal dust is involved in the process of developing coal workers' pneumoconiosis and Claimant was a roof bolter, where he was exposed to a higher concentration of silica, and thus Dr. Tuteur did conclude that Claimant has a pneumoconiotic process. *Id.* Dr. Rasmussen concluded that Claimant suffers from complicated pneumoconiosis which arose from his coal mine dust exposure. He stated that "it is impossible to separate the effects of coal mine dust exposure from that of cigarette smoking, [and so] one must conclude that [Claimant's] coal mine dust exposure was a major contributing factor" to Claimant's total disability. (DX 77, p. 7).

Dr. Zaldivar examined Claimant on August 27, 1997 and reviewed his medical records. Dr. Zaldivar's findings are in a report dated February 13, 1998. (DX 86). Dr. Zaldivar is a board-certified pulmonologist. (DX 28). Claimant reported that he smoked one pack of cigarettes per day until January of 1997, when he switched to smoking two cigars per day; Claimant quit smoking at the beginning of August 1997. Claimant complained of shortness of breath and a productive since 1982, wheezing around perfumes and wood smoke, chest pain, ankle adema, and paroxysmal nocturnal dyspnea. Dr. Zaldivar noted distant breath sounds upon examination. He stated that the pulmonary function study revealed a moderate irreversible obstruction, air trapping by lung volumes, and mild diffusion impairment due to cigarette smoking and emphysema. Dr. Zaldivar also found a high carboxyhemoglobin level of a current smoker. As stated before, Dr. Zaldivar found that there was no evidence of pneumoconiosis on the December 8, 1997 CT scan. Dr. Zaldivar concluded that Claimant does not have simple or

complicated pneumoconiosis, but that he does have emphysema due to cigarette smoking and granulomas in his lungs due to a previous disease. Dr. Zaldivar opined that coal dust exposure did not cause or contribute to Claimant's pulmonary impairment.

Dr. Rasmussen drafted a supplemental letter on January 12, 1999 after reviewing Drs. Zaldivar and Sargent's reports. (DX 100). Dr. Rasmussen recommended that the November 20, 1998 CT scan and Claimant's chest x-rays be interpreted by Dr. Michael Alexander. He stated that "[t]he critical thing in my opinion is the demonstration of pneumoconiosis by x-ray." (DX 100, p. 35).

Claimant was examined by Dr. Zaldivar on November 5, 2003 and his findings are in a report dated November 17, 2003. (EX 1). The miner's complaints included shortness of breath, productive cough, and wheezing. Claimant reported that he began smoking cigarettes at age eighteen and smoked one pack of cigarettes per day until 1997. In 1997, Claimant quit smoking cigarettes and smoked two cigars per day for approximately eight months. Dr. Zaldivar noted that Claimant's lungs were clear to auscultation without wheezes, crackles, or rales. The chest x-ray revealed bullous emphysema and an old scar in the right upper lobe, which may be the result of old tuberculosis. The pulmonary function study revealed moderate irreversible airway obstruction, air trapping by lung volumes, and mild diffusion impairment. Dr. Zaldivar concluded that Claimant has severe bullous emphysema due to his previous intensive smoking habit. In fact, Dr. Zaldivar noted that Claimant's carboxyhemoglobin level is higher than a typical non-smoker, suggesting that he is exposed to second-hand smoke or that he is still smoking. He concluded that Claimant does not have coal workers' pneumoconiosis. Dr. Zaldivar found that Claimant is significantly impaired from a pulmonary standpoint and cannot perform any work above a sedentary level. However, he opined that Claimant's impairment is due his cigarette smoking habit.

Dr. Zaldivar was deposed on January 27, 2004. (EX 4). Dr. Zaldivar noted that he reviewed additional medical records after drafting the November 17, 2003 report. He explained that CT scans are better than chest x-rays because CT scans allow you to "see each individual shadow and what made the shadow" whereas chest x-rays show a "composite view of all the structures of the chest." (EX 4, pp. 12-13). Here, the CT scans show bullous emphysema and a partially calcified and isolated density in the upper lobe that is not surrounded by small densities that could be pneumoconiosis. Also, the calcification resembles linear markings, which is why some physicians read the chest x-rays as positive for pneumoconiosis. In fact, the apparent linear markings are just lung tissue that are trapped and compressed between the bullae. (EX 4, pp. 15-16). Dr. Zaldivar opined that the old infection scars in the upper lobes are due to tuberculosis because Claimant had previously tested positive on a skin test for tuberculosis. (EX 4, pp. 16, 43, 51-53). Dr. Zaldivar testified that coal dust does not cause bullous emphysema, and thus he opined that Claimant's bullous emphysema was due to his history of heavy cigarette smoking. (EX 4, pp. 17, 24). Further, Dr. Zaldivar testified that Claimant's progressive impairment in breathing capacity, high carbon monoxide level in his blood, and bullae in his lungs are consistent with smoking-induced emphysema. (EX 4, pp. 25-26, 36).

Dr. Maria Boustani, a board-certified pulmonologist, drafted a letter dated January 27, 2004. (CX 1). Dr. Boustani stated that she treats Claimant for his pulmonary problems. She

stated that Claimant's May 2003 chest x-ray revealed stable complicated pneumoconiosis with bilateral upper zone granuloma. She also stated that his June 22, 2001 pulmonary function tests revealed moderate obstructive lung disease with a mild decrease in DLCO and post-bronchodilator improvement. Dr. Boustani concluded that these findings "could definitely be consistent with pneumoconiosis." (CX 1, p. 1).

Dr. Peter G. Tuteur was deposed on February 23, 2004. (EX 7). Dr. Tuteur is a board-certified pulmonologist. (EX 7, p. 4). He previously reviewed Claimant's medical records and drafted a consultative report dated September 14, 1993; he reviewed additional medical records in preparation for this deposition. (DX 39; EX 7, p. 5). Dr. Tuteur testified that the chest x-rays and CT scans revealed bullous emphysema. (EX 7, p. 16). Dr. Tuteur explained that the CT scans also revealed old tuberculosis scarring because the scarring was stable throughout the CT scans, Claimant had an "aggressively positive" tuberculin skin test, and there is no evidence that Claimant was exposed to silica, which precludes a finding of silicosis. (EX 7, p. 11). He stated that the apparent linear scarring on the chest x-rays are due to compression of lung tissue due to hyperinflated bullae, and thus are not evidence of coal workers' pneumoconiosis. (EX 7, pp. 12, 21, 33). After reviewing all of the medical evidence, Dr. Tuteur stated that there is no credible medical evidence to indicate that Claimant's coal dust exposure influenced his symptoms, physical examinations, pulmonary function study results, or radiographic studies, and thus he concluded that Claimant does not have medical or legal pneumoconiosis. (EX 7, pp. 12-13, 21-22, 31). Dr. Tuteur diagnosed Claimant with airways obstruction disease due to chronic inhalation of tobacco smoke. (EX 7, p. 13). He explained that Claimant's twelve percent improvement post-bronchodilator and hyperinflation on the 2003 pulmonary function study are consistent with a cigarette smoking-induced lung disease. (EX 7, pp. 24-25).

Hospitalization and Treatment Records

The record contains office notes from Dr. D. L. Rasmussen from November 11, 1993 to December 5, 1996. (DX 75). The record also contains Dr. Rasmussen's office notes from October 28, 1998 to May 2, 2000. (DX 108). Dr. Rasmussen noted reduced breath sounds during every office visit except on February 13, 1995 and May 3, 1999. Claimant repeatedly complained of shortness of breath and a productive cough. During Claimant's office visit on November 24, 1998, Dr. Rasmussen noted that Claimant quit smoking cigarettes in June 1998.

Claimant was hospitalized at Columbia-Raleigh General Hospital from February 2, 1998 to February 13, 1998 for increasing shortness of breath, hypoxia, and an abnormal chest x-ray consistent with right basal pneumonitis. (DX 100). At the time of discharge, Claimant's respiratory status was at "its usual best." (DX 100, p. 2). His discharge diagnoses were: chronic obstructive pulmonary disease with acute exacerbation, right basal pneumonitis, chronic continuous cigarette use, hypoxia, and right ventricular hypertrophy.

Claimant was hospitalized at Beckley-ARH Hospital from June 17 to 21, 1998 for acute respiratory distress and chest pain. (DX 100, 102). His discharge diagnoses included: chronic obstructive pulmonary disease with bullous disease, mostly in the left upper lung, cor pulmonale, pneumoconiosis, and Klebsiella bronchitis.

Conclusions of Law

Before I address the merits of this claim, I must first address a finding made by the district director. In his June 11, 1998 Proposed Decision and Order, the district director held:

> That pursuant to § 725.310 of the Regulations, it is proposed that the ALJ Decision and Order, Award of Benefits dated November 29, 1994, should be modified to a denial because of a mistake in a determination of fact. Medical evidence, unavailable at the time, has been received that shows the previous determination that claimant is disabled due to CWP was incorrect and that his impairment is caused by a condition not related to CWP.

(DX 92, p. 3). However, the Board has held that the district director does not have the authority to modify an award of an administrative law judge. *Cornelius v. Drummond Coal Co.*, 9 B.L.R. 1-40 (1986); *Curry v. Beatrice Pocahontes Co.*, 3 B.L.R. 1-306 (1981). When Judge Holmes remanded this claim to the district director, it was for the purpose of developing additional medical evidence. As of this date, no party has filed a request for modification. Therefore, this case shall not be considered as a request for modification pursuant to § 725.310. I shall address all of the evidence in the record to determine whether Claimant is entitled to benefits.

Benefits are provided to miners who are totally disabled due to pneumoconiosis. § 718.204(a). Claimant has the burden of proving by a preponderance of the evidence that he has pneumoconiosis arising out of coal mine employment and that he is totally disabled as a result. *Gee v. W.G. Moore & Sons, Inc.*, 9 B.L.R. 1-4 (1986). A finding of the existence of pneumoconiosis may be based on chest x-rays, autopsies or biopsies, the presumptions in §§ 718.304, 718.305, or 718.306, and the reasoned medical opinion of a physician that the miner has pneumoconiosis as defined in § 718.201.[6] § 718.202(a)(1)-(4). All types of relevant evidence must be weighed to determine if the miner has pneumoconiosis. *Island Coal Creek Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

There are forty interpretations of eleven x-ray films in the record; of the forty interpretations, seven were read as positive for pneumoconiosis and twenty-nine were read as negative for pneumoconiosis. Four of the interpretations were made during Claimant's hospitalizations and do not address the presence or absence of pneumoconiosis. In evaluating the chest x-ray readings, the qualifications of the physicians reading the x-rays must be taken into account. § 718.202(a)(1). Physicians who are dually qualified as board-certified radiologists and B-readers are entitled to the most weight. *Sheckler v. Clinchfield Coal Company*, 7 B.L.R. 1-128 (1984). Two dually-qualified physicians (Drs. Francke and Speiden) found radiographic evidence of pneumoconiosis. Dr. Patel, a board-certified radiologist, also found radiographic evidence of pneumoconiosis. Six dually-qualified physicians (Drs. Sargent,

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[6] Pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment, and it includes both medical, or clinical, pneumoconiosis and statutory, or legal, pneumoconiosis. § 718.201(a).

Scatarige, Scott, Shipley, Spitz, and Wheeler) found no radiographic evidence of pneumoconiosis. In addition, Dr. Zaldivar, a B-reader, found no radiographic evidence of pneumoconiosis.[7] In his November 29, 1994 decision and order, Judge Holmes found that Claimant demonstrated the presence of pneumoconiosis by the chest x-ray evidence. (DX 43). However, at that time the record contained seven interpretations of two chest x-rays, four of which were positive for pneumoconiosis. The record now contains a substantially greater number of interpretations, a majority of which are negative for pneumoconiosis. Moreover, a preponderance of the x-ray interpretations demonstrate that the mass in Claimant's right upper lung that was originally diagnosed as complicated pneumoconiosis is actually scarring from an inflammatory disease. These interpretations are supported by the medical evidence, which shows that Claimant previously suffered from tuberculosis. Based on the foregoing, I find that a preponderance of the chest x-ray evidence fails to establish the existence of pneumoconiosis.

The record also contains seven interpretations of four CT scans. Every physician identified bullous and/or centrilobular emphysema on the CT scans. Drs. Fishman, Navani, Sargent, Scatarige, and Zaldivar found that the mass in Claimant's right upper lobe was due to an inflammatory process, such as tuberculosis or histoplasmosis, and was not complicated pneumoconiosis. Dr. Patel found that the mass in the right upper lung was consistent with complicated pneumoconiosis or retractive fibrosis associated with old, healed tuberculosis. Dr. Navani found changes in the right lung and left mid and lower lung zones that were consistent with simple pneumoconiosis, but stated that "these densities are non-specific and [could] be due to extrisic [*sic*] insult caused by coal dust or heavy cigarette smoking; haemosiderosis, sarcoidosis, collagen diseases such as scleroderma or systemic lupus erthematosis, drug-induced pulmonary fibrosis, fibrosing alveolitis or diffuse infiltrative pulmonary fibrosis." (CX 116, p. 1). I find that Drs. Patel and Navani's interpretations of complicated pneumoconiosis and simple pneumoconiosis, respectively, are equivocal and thus I accord them less weight. I find that Drs. Fishman, Navani, Sargent, Scatarige, and Zaldivar's interpretations of scarring from an old inflammatory process are supported by the medical evidence because Claimant has previously tested positive for tuberculosis. I find that their interpretations are reasoned, and thus I accord more weight to Drs. Fishman, Navani, Sargent, Scatarige, and Zaldivar. I find that a preponderance of the CT scan evidence fails to establish the presence of simple or complicated pneumoconiosis.

There is no biopsy evidence and the other enumerated presumptions are not applicable to this claim.

The record contains the medical opinions of five physicians and the findings of the West Virginia Occupational Pneumoconiosis Board (WVOPB). The WVOPB found that Claimant

[7] Dr. Zaldivar initially interpreted the April 29, 1991 and May 20, 1992 chest x-rays as positive for pneumoconiosis and complicated pneumoconiosis, respectively. (DX 14, 27). In a letter dated May 28, 1993, Dr. Zaldivar changed his interpretations of the chest x-rays after reviewing Drs. Shipley, Spitz, and Wiot's interpretation of the April 29, 1991 chest x-ray and Dr. Fishman's interpretation of the September 14, 1992 CT scan. He stated that the x-rays did not reveal pneumoconiosis or complicated pneumoconiosis, but rather were consistent with emphysema and scarring from a prior inflammation. (DX 37).

suffers from occupational pneumoconiosis based on a positive chest x-ray. Dr. Craft diagnosed complicated pneumoconiosis based on a positive chest x-ray. Dr. Rasmussen diagnosed coal workers' pneumoconiosis based on a positive chest x-ray and chronic bronchitis based on Claimant's history of a productive cough. Dr. Boustani found that Claimant's chest x-ray and pulmonary function study results "could definitely be consistent with pneumoconiosis." (CX 1). Drs. Tuteur and Zaldivar diagnosed bullous emphysema due to tobacco smoking. Dr. Tuteur also diagnosed chronic bronchitis due to tobacco smoking.

The WVOPB found the existence of occupational pneumoconiosis in its determination letter. While a state agency determination is relevant, it is not binding on this court. *Schegan v. Waste Management & Processors, Inc.*, 18 B.L.R. 1-41 (1994). First, the determination letter does not state the criteria for a finding of "occupational pneumoconiosis." Second, the WVOPB simply identified the medical evidence they relied upon; none of the evidence is appended to the determination letter. Third, I previously found that a preponderance of the chest x-ray evidence is negative for pneumoconiosis, and thus the WVOPB's finding is not supported by the x-ray evidence of record. For these reasons, I accord little weight to the WVOPB's determination letter.

I also find that Drs. Boustani, Craft, and Rasmussen's diagnoses of pneumoconiosis are not supported by the x-ray evidence of record because a preponderance of the chest x-ray evidence is negative for pneumoconiosis. As Drs. Craft and Rasmussen did not state any other reasons for their diagnoses of pneumoconiosis, I find that their opinions are not supported by the medical evidence and thus are entitled to little weight. Dr. Boustani also diagnosed pneumoconiosis based on the results of a pulmonary function study. The Board has held that pulmonary function studies are not diagnostic of the presence or absence of pneumoconiosis. *Burke v. Director, OWCP*, 3 B.L.R. 1-410 (1981). I find that Dr. Boustani's opinion is not reasoned and accord it little weight.

It is well-settled that pneumoconiosis has both a medical and legal definition. § 718.201(a); *see also Clinchfield Coal Co. v. Fuller*, 180 F.3d 622, 625 (4th Cir. 1999); *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 821 (4th Cir. 1995). Medical pneumoconiosis is a lung disease diagnosed by x-ray opacities indicating nodular lesions on the lungs. *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 7 (1976); *see also* § 718.201(a)(1). Legal pneumoconiosis is a broader category of diseases, and includes "any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment." § 718.201(a)(2); *see also Hobbs*, 45 F.3d at 821. Section 718.201(b) defines "arising out of coal mine employment" as any chronic respiratory or pulmonary impairment "significantly related to, or substantially aggravated by, [coal] dust exposure." Evidence that does not establish medical pneumoconiosis, i.e., an x-ray read as negative for pneumoconiosis, is not evidence against establishing legal pneumoconiosis. *Hobbs*, 45 F.3d at 821.

Dr. Rasmussen diagnosed chronic bronchitis due to Claimant's coal dust exposure and history of cigarette smoking. Dr. Tuteur diagnosed chronic bronchitis due to Claimant's history of tobacco smoking. The Board has held that chronic bronchitis falls within the regulatory definition of pneumoconiosis (i.e., legal pneumoconiosis) if it is related to the claimant's coal mine employment. *Hughes v. Clinchfield Coal Co.*, 21 B.L.R. 1-134 (1999). Dr. Rasmussen's

opinion contains a cursory statement that Claimant's chronic bronchitis is due to both coal dust exposure and cigarette smoking; he does not provide any support for his conclusion. I find that Dr. Rasmussen's opinion is not well-documented or well-reasoned, and thus accord it little weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Dr. Tuteur concluded that Claimant's chronic bronchitis is due to tobacco smoking, but when asked to elaborate, he merely discussed the medical literature and stated "by my guesstimate the true frequency of coal miners who develop the phenotype of chronic obstructive pulmonary disease due to the inhalation of coal mine dust is in the range of one percent or substantially less." (EX 7, pp. 13-14). I find that Dr. Tuteur's opinion as to Claimant's chronic bronchitis is not reasoned because he does not explain how he concluded that coal dust exposure did not contribute to Claimant's chronic bronchitis.

Drs. Tuteur and Zaldivar diagnosed bullous emphysema due to tobacco smoking. Dr. Zaldivar concluded that Claimant suffered from tobacco-induced bullous emphysema because "the main cause of bullous emphysema is smoking…. [and] coal mining does not cause bullous emphysema," (EX 4, p. 17), the CT scan evidence confirms the presence of bullous emphysema, and the x-rays did not reveal any evidence that Claimant's lungs reacted with inhaled coal dust (i.e., no coal worker's nodules). (EX 4, pp. 18-24, 47). I find that Dr. Zaldivar's opinion is reasoned, and thus accord it significant weight. Dr. Tuteur concluded that Claimant has bullous emphysema due to tobacco smoking based on the x-ray and CT scan evidence. He also concluded that Claimant does not suffer from pneumoconiosis because there is no evidence that coal dust exposure influenced his symptoms, physical examinations, pulmonary function studies, or chest x-rays. Dr. Tuteur did not examine Claimant, but he did have an opportunity to review all of the medical evidence in the record. A non-examining physician's opinion may constitute substantial evidence if it is corroborated by the opinion of an examining physician or by the evidence considered as a whole. *Newland v. Consolidation Coal Co.*, 6 B.L.R. 1-1286 (1984); *Easthom v. Consolidation Coal Co.*, 7 B.L.R. 1-397 (1987). I find that Dr. Zaldivar's report and the evidence as a whole corroborate Dr. Tuteur's opinion as to bullous emphysema. I also find that Dr. Tuteur's opinion is reasoned and therefore accord it significant weight. In sum, I find that the medical opinion evidence does not establish the presence of legal pneumoconiosis.

As stated above, I am required under *Compton* to weigh all of the evidence together to determine if Claimant has established the existence of pneumoconiosis. 211 F.3d at 211. I previously found that the chest x-ray, CT scan, and physician opinion evidence does not establish coal workers' pneumoconiosis. After weighing all of the evidence together, I find that Claimant has failed to establish the existence of pneumoconiosis.

A miner shall be considered totally disabled if the irrebuttable presumption in § 718.304 applies. If that presumption does not apply, a miner shall be considered totally disabled if his pulmonary or respiratory impairment, standing alone, prevents him from performing his usual coal mine work and comparable and gainful work. § 718.204(b)(1). In the absence of contrary probative evidence, a miner's total disability shall be established by pulmonary function studies showing the values equal to or less than those in Appendix B, blood gas studies showing the values in Appendix C, the existence of cor pulmonale with right sided congestive heart failure, or the reasoned and documented opinion of a physician finding that the miner's pulmonary or

respiratory impairment prevents him from engaging in his usual coal mine work and comparable and gainful work. § 718.204(b)(2).

The record contains five pulmonary function studies. Four of the five pulmonary function studies produced qualifying results. I find that a preponderance of the pulmonary function study evidence establishes that Claimant is totally disabled.

The record contains six arterial blood gas tests. The February 2, 1998, February 13, 1998, and November 5, 2003 arterial blood gas tests produced qualifying results. As the most recent arterial blood gas test produced qualifying results, I find that a preponderance of the arterial blood gas test evidence establishes total disability.

I find that the isolated diagnosis of cor pulmonale during Claimant's June 1998 hospitalization does not establish that he is totally disabled.

The record contains the medical opinions of three physicians and the WVOPD determination letter.[8] The WVOPB letter states that Claimant suffers a thirty percent pulmonary impairment. For the reasons stated before, I find that the WVOPB determination letter is poorly reasoned and accord it little weight. Dr. Rasmussen found that Claimant suffers from a moderately severe impairment, based on the pulmonary function study and arterial blood gas test results, and that the impairment prevents him from performing his former coal mine employment. Dr. Zaldivar found that Claimant is significantly impaired, based on the breathing and exercise tests, and concluded that he cannot perform work above a sedentary level. Dr. Tuteur found that Claimant is totally disabled due to a pulmonary impairment. I find that the objective medical evidence supports the findings of the physicians, and thus accord their opinions great weight. I find that a preponderance of the physician opinion evidence establishes that Claimant is totally disabled.

Weighing all of the evidence together, I find that Claimant has established that he is totally disabled. However, the evidence does not show that Claimant has pneumoconiosis, and thus he cannot prove that he is totally disabled due to pneumoconiosis. His claim will therefore be denied. Claimant's counsel is precluded from receiving a fee for his legal work on this case.

ORDER

IT IS ORDERED THAT the claim of Terry K. Belcher is DENIED.

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DANIEL L. LELAND
Administrative Law Judge

[8] Drs. Boustani and Craft did not address whether Claimant is totally disabled, and therefore their opinions are not probative on this issue.

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601***. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C.